

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 22 1960

317

541

60-029067

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Clayton		c. CITY OR TOWN Overland	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Louis		d. STREET ADDRESS (If outside, give location) 9435 Tennyson	
3. NAME OF DECEASED (Type or print) First George Middle Wohldmann Last 		4. DATE OF DEATH Month July Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Co Court Bldg	11. BIRTHPLACE (City and state or country) St Louis Co Mo
13a. FATHER'S NAME Hans Wohldmann		13b. MOTHER'S MAIDEN NAME Emma Lamker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 498-03-7841	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		12. CITIZEN OF WHAT COUNTRY USA 14. NAME OF HUSBAND OR WIFE Eugenia 17. INFORMANT Carl Wohldmann Hazelwood Mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Overland	
21. I attended the deceased from 11 July 60 to 11 July 60 and last saw him alive on 11 July 60 Death occurred at 2:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 7/12/60	
22a. SIGNATURE (Deedee or title) Herman J. Rodman M D		22b. ADDRESS 2428 Woodson Overland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/14/60	23c. NAME OF CEMETERY OR CREMATORY St Ferdinand	23d. LOCATION (City, town, or county) Florissant Mo
24. FUNERAL DIRECTOR Ortmann F Home		25. DATE RECD. BY LOCAL REG. 7-13-60	
26. REGISTRAR'S SIGNATURE J. B. Murphy M.D.			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 12 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Al Q. Ostmann

Licensed Embalmer No. 3478

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.